Grow Well Summary of Recommendations

November 2019

Overview

In preparation for Henry County Medical Center (HCMC)'s application to the Health Resources and Services Administration (HRSA) funding opportunity for the Delta States Rural Development Network Grant Program, a range of primary and secondary data was analyzed by Conduent Healthy Communities Institute (HCI) to inform community health efforts in the Western Tennessee region related to three priority areas:

- Behavioral Health
- Children's Health
- Chronic Disease

Secondary data related to community health and quality of life were examined for the 18-county service area comprised of: Benton, Carroll, Chester, Decatur, Dyer, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Tipton, and Weakley.

In addition to secondary data, community input (primary data) was gathered to understand community barriers, needs and opportunities. HCMC stakeholders and partners involved in the Grow Well regional initiative were invited to complete an inventory of existing community programs, services and populations reached. Findings from the inventory informed the design of an online community survey as well as focus group questions on health needs and access barriers in the region.

Secondary and primary data findings informed the investigation of evidence-based strategies and the resulting recommendations for community health improvement efforts.

Secondary Data Update

This section includes data on the following indicators:

Adults 20+ with diabetes
Adults 20+ who are Obese
Age-Adjusted Death Rate due to Coronary Heart Disease
Age-Adjusted Death Rate due to Cerebrovascular Disease
Self-Reported General Health Assessment: Poor or Fair
Persons with Health Insurance
Adults with health insurance
Children with health insurance: Under 19
Access to Exercise Opportunities
Calculation: Health Care Costs / Median Income
Uninsured Adults
Uninsured Children
Dentist Rate
Mental Health Provider Rate
Primary Care Provider Rate
Non-Physician Primary Care Provider Rate

Since the secondary data analysis conducted in early 2019, several sources have updated their data. These sources include County Health Rankings and the U.S. Census Bureau's Small Area Health Insurance Estimates program. Below is a summary of the key findings from the updated secondary data analysis.

Access to Health Services

Persons with health insurance (0-64 years old): between 2016 and 2017, the majority of counties in the service area saw a decrease in coverage; Gibson: 1.7% decrease, Hardeman: 1.4% decrease, Haywood: 1% decrease and Carroll: 1% decrease

- Trend: 2016-2017

County	Persons with Health Insurance (2016)	Persons with Health Insurance (2017)
Benton	88.2	87.6
Carroll	90.1	89.1
Chester	88.4	88.2
Decatur	87.9	87.9
Dyer	90.1	90.2
Gibson	90.8	89.1
Hardeman	89.1	87.7
Hardin	88.4	88.2
Haywood	89.6	88.6
Henderson	88.9	88.9
Henry	88.3	88.8
Lake	88.8	88.4
Lauderdale	88.8	88.1
McNairy	88.1	88.6
Madison	90.9	90.4
Obion	88.9	88.2
Tipton	90.1	90.9
Weakley	90.4	89.7
Tennessee	89.4	88.7

Behavioral Health

Mental health providers per 100,000 members of population, in 2018:

- 15 counties in the 18-county service area have a lower mental health provider rate than the state of Tennessee
- Henry and Madison counties were the only two counties that had a higher mental health provider rate than the state of Tennessee
- Lake, Lauderdale, and Gibson counties have the lowest mental health provider rates among the 18 counties

Children's Health

Children with health insurance

- 6 counties in the service area have a lower rate of health insurance among children than the state of Tennessee

Chronic Disease

Adults 20+ with diabetes

- 15 counties in the service area have a higher rate of diabetes than the Tennessee state value

Age-Adjusted death rate due to coronary heart disease

- 5 counties in the service area have a higher rate of coronary heart disease than the Tennessee state value

Exercise, Nutrition and Weight

Access to exercise opportunities: percentage of individuals who live reasonably close to a park or recreational facility, for 2019:

- 16 counties in the service area have a lower value than state of Tennessee
- Obion and Madison counties are the only counties to have higher values than the state value
- Carroll, Weakley and Lake counties have the lowest levels of access to exercise opportunities

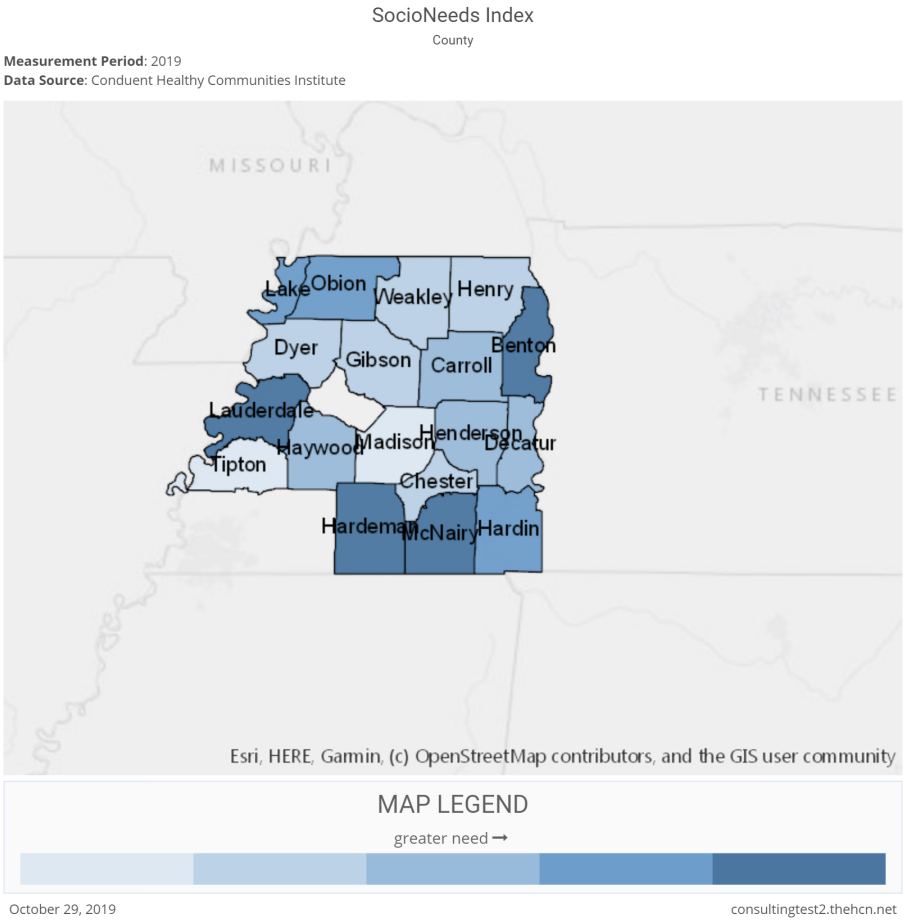
Adults 20+ who are obese, in 2015:

- 15 out of the 18-county service area have a higher percentage of obese population than the state of Tennessee
- Hardeman, Lauderdale and Dyer counties have the highest percentage of obese adults in the region
- McNairy, Henderson and Hardin counties have the lowest levels of obesity in the region

SocioNeeds Index

The 2019 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. The SNI takes into account data related to poverty, education, linguistic barriers, and correlates that data with preventable hospitalizations and premature death.

All counties in the region are given an Index Value from 0 (low need) to 100 (high need). To help you find the areas of highest need in your community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their Index Value.



Please refer to the secondary data update workbooks in the *Appendix* for a more detailed breakdown.

Primary Data (Community Input)

Three methods were used to collect community input:

- Stakeholder resource inventory
- Focus group discussions
- Online community survey

Stakeholder Resource Inventory

The purpose of developing a resource inventory was to create a list of available services and programs across the 18 counties specifically for behavioral health, chronic diseases, and children's health. Using a web-based survey tool, we reached out to community stakeholders across the region to document community health resources. These key individuals have first-hand knowledge of their community and specific health areas. Many participants were selected based on their experience providing services directly in the region. 39 stakeholder respondents completed the online resource collection tool. The results were sorted by content area and are included in the *Appendix*. Since these resources have been selected and recommended by key stakeholders, they may be considered essential resources in the region.

To build on the resources collected from key stakeholders, a supplementary resource inventory search was conducted using the Community Resource Referral Platform (CRRP), AuntBertha.com (https://www.auntbertha.com/). Resources were identified as either 'State or National' resources or 'Serving the local area' and sorted accordingly. Resource sections that were scanned in AuntBertha.com included:

- **Health**/Medical Care/Prevent & Treat
- **Care**/Community Support Services/ Recreation and Exercise
- **Food**/Meals and Nutrition Education

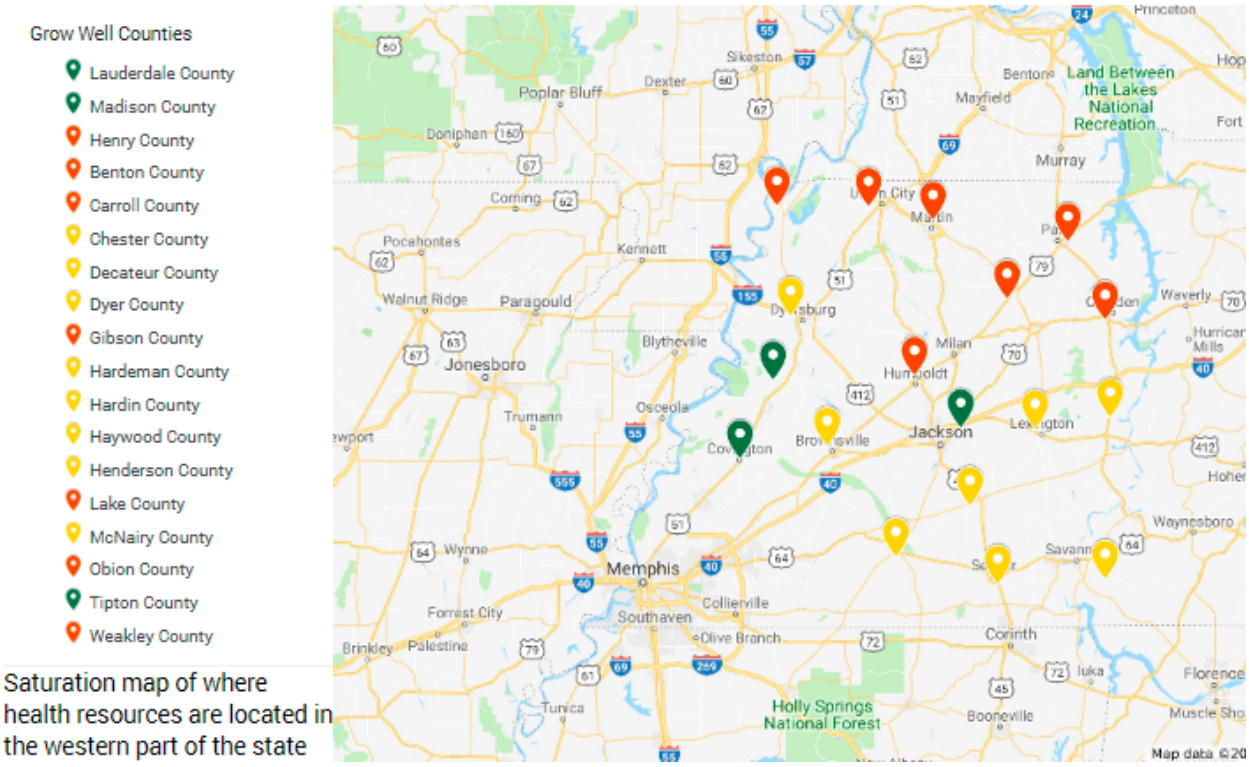
Using the higher populated zip codes in each of the counties to search the CRRP, a rudimentary count was done to identify local resources available. The full count and saturation map of resources is available below. A full list of all resources collected by county can be found in the *Appendix*. In seven counties, less than five resources were found through the CRRP search and in ten counties, between five and ten resources were found. Only three counties had more than ten resources found through the search; Tipton County had by far the most resources. It is important to note that this is a thorough, but not comprehensive list of resources in the community and some resources may not have been identified through this resource inventory development process.

Table 1 Local Resources Identified by Web-based Search

County	Zip Code(s)	# of Resources
National/ State	NA	24
Henry	38242	3
Benton	38320	2
Carroll	38201/38344	2
Chester	38340	6
Decatur	38363	6

County	Zip Code(s)	# of Resources
Dyer	38024	5
Gibson	38343/38358	4
Hardeman	38008	6
Hardin	38372	6
Haywood	38012	7
Henderson	38351	8
Lake	38079	3
Lauderdale	38063	16
Madison	38305/38301	19
McNairy	38375	7
Obion	38261	2
Tipton	38019	74
Weakley	38237	4

Figure 1 Saturation Map of Resources by County



Key:
Orange – limited resources [>5]
Yellow – some resources [5-10]
Green – more resources [10+]

Focus Group Discussions

The goal of the focus group discussions was to gain a better understanding of the barriers individuals in the community experience accessing programs and services for chronic disease, mental health, and children's health. The questions in the focus group guide (see *Appendix*) concentrated on how to improve health in the community, beliefs about chronic disease/mental health, and knowledge about chronic disease and mental health. The discussion during the sessions also revealed opportunities for strengthening or expanding existing resources and efforts. Three focus groups took place over a two-day period in three different counties across the region and included a total of 25 participants. A complete list of the key findings is listed in the table below for each focus group. The findings from the focus groups were used to develop the list of recommendations for evidence-based practices. The primary themes emerging from all the focus group discussions on how to improve health in the region were:

- Stakeholders have a desire for more regional collaboration
- To address mental health, need to contest stigma about seeking help
- In areas with limited resources, find alternative ways to encourage physical activity and promote healthy behaviors
- There are opportunities for partnership, such as developing programs with schools to improve children's health and development

Table 2 Focus Group Dates and Locations

Date	Time	Location	Number of Participants
Wednesday 9/11/19	8:30-10am	**Jackson** LeBonheur Children's Outpatient Center	8 attendees
	1-2:30 pm	**Paris** Henry County Medical Center Classroom 2&3	11 attendees
Thursday 9/12/19	8:30-10am	**Bolivar** Hardeman County Community Health Center	6 attendees

Table 3 Focus Group Key Findings

Jackson	*Paris*	*Bolivar*

• Misconception that chronic disease is not preventable
  ○ Lack of sense of urgency
  ○ Lack of understanding and education available
  ○ Early education and early intervention are needed
	• There is a lack of prevention for chronic disease
	• SES/Education play a role in uptake of preventative care
	• Cost is a barrier for getting chronic disease care
	• Mental health issues are stigmatized
	• Cost is a barrier to getting
		• Chronic disease is not seen as preventable
		• Cost is a major barrier to accessing care
		• Mental health is stigmatized
		• Cultural beliefs are a barrier to uptake of mental health care
		• Need to educate

Jackson	*Paris*	*Bolivar*
• Lack of availability of mental health providers • Mental health is stigmatized ○ Needed: crisis intervention training and educating community about programs available • Socioeconomic status (SES) issues cause people to prioritize other issues • Children's health: leverage existing school events	mental health care • Lack of mental health providers in the community • Need to educate community on these issues and resources available • Children's weight and physical activity is a concern • Parents lifestyle influences child's behavior • Need more programs to address children's health (ex. Mentoring programs) • Lack of transportation is a barrier to accessing health care	community on mental health issues • Childhood obesity is a concern in the community • Perception that eating healthy is expensive • Lack of behavioral health providers for children • Miseducation and parent's lifestyle set children up for engaging in unhealthy behaviors

Community Survey

A web-based community survey was developed and distributed to collect additional information about children's health, access to services, chronic disease, exercise, nutrition, food insecurity, community infrastructure, and mental health. The questions were designed to learn more about:

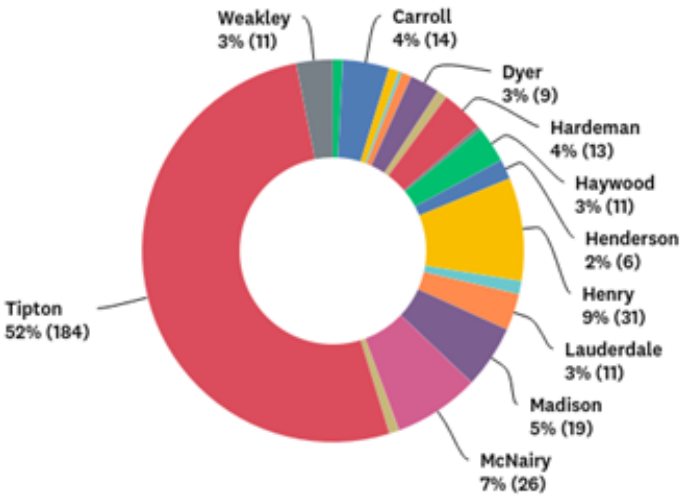
- Perceived personal health and community needs
- Utilization and knowledge of programs and services
- Access to services and barriers

The survey was opened on September 15, 2019 and closed on October 5, 2019. The survey was distributed by the Grow Well team and community stakeholders. 356 community members completed the survey with representation from across the 16 counties. Representation across the county was not equivalent and the results should be considered informative but not entirely representative of the region. The majority of respondents were from Tipton County (52%, 184), while some counties had between one and three respondents (Benton, Chester, Decatur, Gibson, Hardin, and Obion). The survey was analyzed by age group and for certain questions the results were assessed by county. A full summary of the analysis, with graphs, is available in the *Appendix* and key highlights from the survey are below.

Survey Demographics

- Majority of survey respondents were from Tipton County (52%, 184)
- 52% between the ages of 35-44 (24%, 84) and 45-54 (28%, 99)
- 89.3% White/Caucasian, 7% Black/African American
  - 1% (3) are Hispanic Latino, 2% (6) Prefer not to answer
- 99.7% (354) speak English as their primary language
- 47.2% (168) have Children; most participants had two or fewer children in the home

Figure 2 Survey Representation by County



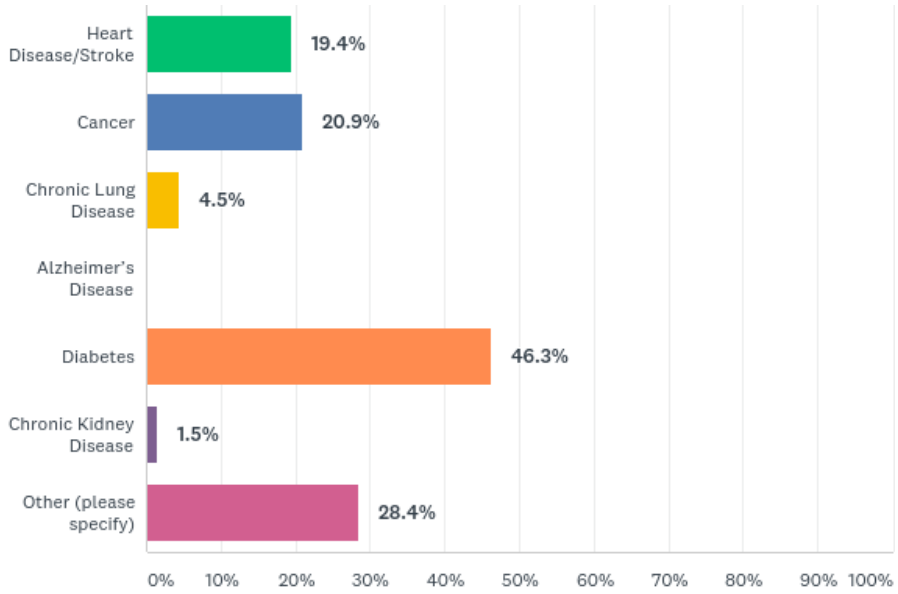
Access to Health Care – Preventative Services

- 94.2% (146) had accessed health care services for their child/children (any service type) for any reason;
    - 15.5% (24) of respondents said that none of the children in the home had had a well-child visit
    - 5.8% (9) of respondents said that some but not all of the children in the home had had a well-child visit
- 15.5% (47) adults had not had a preventative check-up with a health provider in the past 12-months
- Participants (179) selected which health related activities or services they wanted more of in their community:
    - 14.0% (25) wanted regular meetings with other who have similar health conditions
    - 26.3% (47) wanted informational materials to better manage their health
    - 39.1% (70) wanted community events with health professionals that know about their health condition
    - 45.3% (81) wanted health care follow up that does not require travel to a clinic such as email, text messages, phone or video appointments
    - 13.4% (24) selected other

Chronic Disease

- 22.4% (70) have been told by a health care professional that they have a chronic health condition or disease
    - Of those who said they have been told they have a chronic health condition or disease, 46.3% (31) had been told they had Diabetes

Figure 3 Chronic Diseases by Type



- Of those participants (24) who had challenges seeking services for their chronic disease;
  - 37.5% (9) said they experienced issues related to costs
  - 20.8% (5) said that the services that they needed were not available in their area
  - 20.8% (5) said that the clinic office wasn't open when they needed care
- Participants were asked about the quality of their chronic disease health care services and availability of community services:
  - 26.6% of participants 'somewhat disagree' or 'definitely disagree' that their provider has shared information about programs that can join in their community to help them manage their health condition – the age group most impacted are 35-44 and 75+
  - 47.7% of participants 'somewhat disagree' or 'definitely disagree' that there are programs, groups or events in their community to help them to manage their health condition – the age groups most impacted are 25-34, 35-44 and 45-54
  - Age groups 35-44 and 65-74 reported more difficulty scheduling follow-up appointments with their provider and less likely to receive information materials about their condition from their provider
  - The following age groups may benefit from health goal conversations related to their chronic disease with their providers: 25-34, 35-44, 45-54, 55-64, and 75+
  - Age groups 35-44 and 75+ are less likely to receive periodic follow up and check-ins from their provider about their chronic disease
  - Age groups 25-34 and 75+ were more likely to disagree that all their providers are aware of their health condition and they do not have to repeat themselves at appointments

Nutrition/Food Security

- 19.5% (60) said they could afford enough to eat but not always the kinds of foods they should eat and 2.6% (8) said they sometimes could not afford enough to eat
- Participants (73) selected which nutrition related activities they would like to have more of in the community (they could select all that applied):
    - 38.4% (28) – Easy Access to a food pantry that stocks healthy food items
    - 43.8% (32) – Cooking demonstrations with low cost recipe options
    - 57.5% (42) – More farmers markets and community gardens
    - 68.5% (50) – Information about how to choose healthy foods within my budget

Exercise

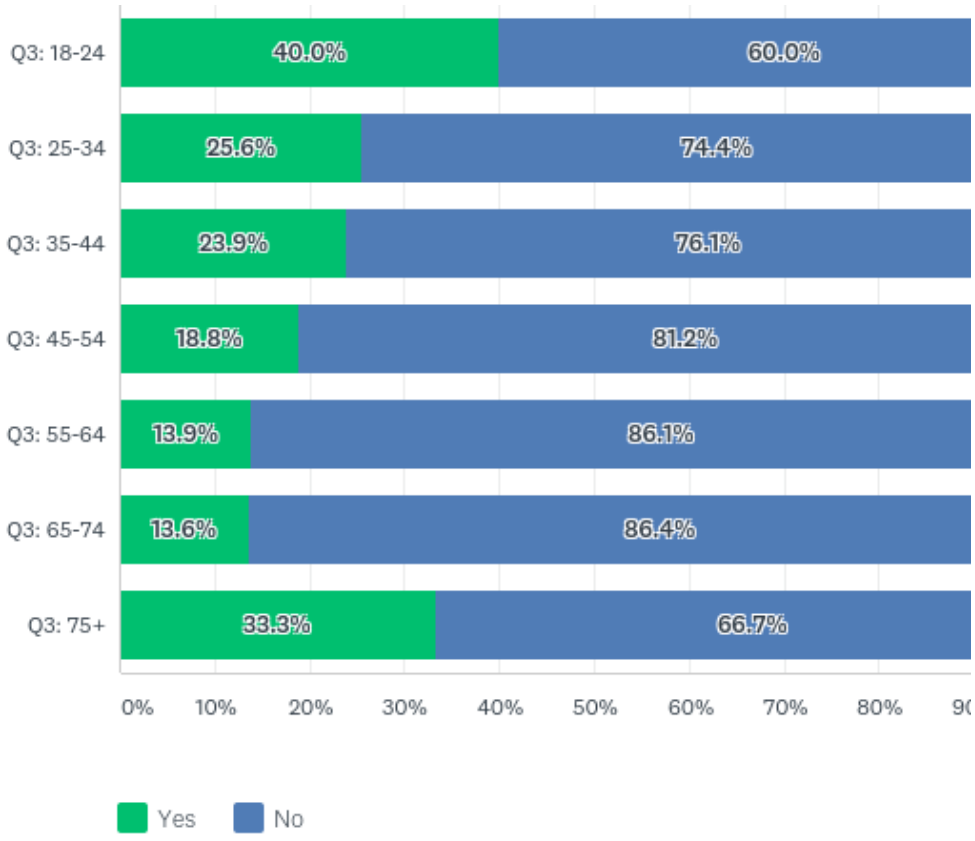
- 30.8% (97) exercised zero times in the past week for at least 60 minutes
- 48.9% (154) exercised one to three times in the past week for at least 60 minutes
- 7.4% (11) reported that none of the children in the home and 6.8% (10) reported that some of the children in home participated in physical activity for at least 60 minutes on three or more days
    - Common comments from participants were about the lack of physical education classes and programs in schools
- Participants were asked how much they agreed or disagreed with a series of questions about the community infrastructure and environment. The survey results reflected that some counties had higher need for more sidewalks/walking paths, low-cost exercise facilities, and an improved overall neighborhood environment (ex. Housing, vandalism, and clean streets):
    - Improving sidewalks and/or walking paths may be needed more in Gibson, Henderson, Lauderdale, Madison, and Tipton Counties according to community survey respondents; Overall survey disagreement was 37.2% across the region
    - Respondents in Carroll, Decatur, Gibson, Hardeman, Henderson, Lake, Weakley Counties disagreed, more than respondents from other counties, that there were low-cost gyms or recreation centers in their community; Overall survey disagreement was 45.4% across the region

Mental Health

- 9.1% (14) reported that a child/children in the home needed treatment or counseling from a mental health professional
- 20.1% (61) had been told by a health care professional that they have a mental health condition
    - Age groups 17-24 and 75+ reported slightly more mental health diagnosis than other groups
- 51.7% (148) said that they had NOT been asked by a health provider about their mental health and well-being
- Participants (147) were asked which mental health services or programs they would like more of in their community:
    - 17.0% (25) wanted regular meetings with others in the community about mental health and well-being
    - 20.4% (30) wanted informational materials to help better manage their health condition
    - 47.6% (70) wanted community events with health professionals that know about mental health

- 34.7% (51) wanted mental health services that do not require travel to a clinic such as email, text messages, phone or video appointments
- 18.4% (27) selected 'other'

Figure 4 Mental Health Diagnoses (Y/N) by Age



Recommendations

Best practices and evidence-based interventions were identified based on findings from the analysis of secondary and primary data as well as through the examination of national resources and the Promising Practices database on HCMC's Community Health Needs Assessment platform (https://www.hcmc-tn.org/about-hcmc/our-community/community-health-information).

Before initiating any health-focused program or activity, the following are considerations to support and build on existing community health improvement efforts being implemented by Grow Well, HCMC and other partners in the Western Tennessee region.

- Strengthen and sustain a regional network
- Leverage promising practices
- Promote regional efforts
- Establish an evaluation framework
- Implement policy, systems and environmental change

Links to online resources and further information are included in the *Tools and Resources* section.

Strengthen and Sustain a Regional Network

Findings from the stakeholder resource inventory and focus group discussions revealed: ongoing efforts in the region related to community health improvement; general awareness of community barriers and needs; and individual and organizational interest in collaboration. Some challenges that were noted include a limited infrastructure for collaboration as well as inconsistent communication and coordination between stakeholders, partners and community members, further impacted by the broad expanse of the rural service area.

To establish a stronger regional collaborative or network, and to increase the coordination, sustainability and impact of efforts, the following are suggested considerations.

Strengthen the Framework for Collaboration

Stakeholders expressed their commitment to community health improvement and their interest in collaborating. However, some were not aware of other organizations and therefore were not coordinating nor aligning their efforts.

The collective impact framework is useful for coordinating the activities of multiple organizations and individuals through a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a backbone organization. The **Collective Impact Forum** has outlined Principles of Practice for collective impact efforts to be effective, including (but not limited to): involving community members in the collaborative; engaging cross-sector partners; focusing on system strategies; and customizing for local context. As noted, an essential component of the collective impact framework is the backbone organization. The backbone organization convenes partners and stakeholders, facilitates communication, and supports the coordination of efforts (including data collection and analysis), among other activities.

Furthermore, as described by the **Community Toolbox**, a collaborative must implement specific steps to create and maintain partnerships. In addition to establishing the group's shared vision, mission, and

objectives, it is vital to identify existing (and potential) barriers and solutions, develop an infrastructure for the collaboration (including a governing structure for decision-making) and define clear roles and responsibilities.

Additional considerations for engaging partners in collaborative efforts and implementing a community engagement plan are delineated in **CDC's *Principles of Community Engagement*.** (See links listed in *Tools & Resources*.)

Facilitate Regular Communication

Establishing regular communication between stakeholders, partners and community members can help to increase awareness of existing and new efforts in the region, participation in various meetings and working groups, and involvement in community-wide events.

HCMC's Community Health Needs Assessment online platform can be leveraged as a central collaboration and communication tool to share information on upcoming/standing meetings, community events and locations, reports, and other useful resources. The platform can support users to gain insights from data, identify disparities, plan and implement initiatives, collaborate and communicate to make a difference. An additional platform-related resource is described further in the *Leverage Promising Practices s*ection.

Build Capacity

During focus group discussions it was noted that trainings would help build the capacity of service providers and other community stakeholders to recognize and address issues such as mental health crises.

National programs and resources, such as **Mental Health First Aid**, may be leveraged to increase awareness of and develop skills to respond to the signs of mental health and substance use issues. In addition, if cross-sectoral stakeholders are involved in the collaborative, different areas of expertise can be shared amongst partners to increase knowledge and skills (e.g., business, education, health, law enforcement, social services, transportation, etc.), thereby building the capacity of the regional collaborative to address community-wide issues through different approaches.

There is also the opportunity to ensure consistent and robust application of the **Chronic Care Model (CCM)** regionally to support practitioners treating individuals living with chronic disease. The MacColl Center for Healthcare Innovation at Kaiser Permanente Washington Health Research Institute has created a **Primary Care Team Guide** to support teams to assess the current state of their clinic and provides guidance on building processes to provide robust care to patients with chronic diseases.

The **Robert Wood Johnson Foundation** describes the importance of building a culture of health through cross-sector collaboration, in recognition that no single organization can change the health of a community alone. For cross-sector collaboration to be effective, quality partnerships must be established, investments made to support collaboration, and policies implemented to encourage collaboration.

Leverage Promising Practices

In order to be effective, community health improvement strategies must take into consideration the community's context, history and socioeconomic factors. Although each community is unique, lessons learned and best practices from other communities can be reviewed and adapted as needed.

Consider Interventions for Rural Communities

The **Promising Practices database** on HCMC's Community Health Needs Assessment platform is comprised of over 2,000 best practices, recommendations and ideas, which can be filtered by type, target audience, topic and sub-topic, as well as geography.

For example, community input revealed limited access to exercise and physical activity opportunities. Focus group participants and survey respondents reported low weekly physical activity and challenges with fitting physical activity into their daily life. Many survey respondents with children shared that physical education is not available during the school day. The following are snapshots of evidence-based practices focused on Health>Exercise, Nutrition and Weight in rural communities. (For details, see the Promising Practices database.)

- The **Winning With Wellness** (WWW) project in Tennessee included the following eight program areas: nutrition services, health education, physical education, school health services, counseling and psychological services, healthy school environment, school site health promotion for staff, and family and community involvement.
- The **Bootheel Heart Health Project** was launched by the Missouri Department of Health and Senior Services and the CDC to help communities in southeastern Missouri form local Heart Health coalitions.
- **Pounds Off With Empowerment (POWER)** is a lifestyle intervention for diabetic persons in rural communities.
- **Strong Women – Healthy Hearts** is a lifestyle intervention to promote cardiovascular health among rural middle-aged women through physical activity and healthy eating.

Additional resources such as the **Rural Health Information Hub** offer a range of information, resources and examples of interventions that have been shown to be effective in rural communities.

Use a Balanced Portfolio of Interventions

Furthermore, it is recommended to implement a range of interventions.

In order to achieve greater impact, **CDC's Community Health Improvement Navigator** describes the importance of implementing interventions that work across four action areas: socioeconomic factors; physical environment; health behaviors; and clinical care. Infographic and presentation resources are available on the CDC's CHI Navigator site to support meetings and discussions with community partners and members.

Figure 5 CDC CHI Navigator: 4 Considerations to Improve Health & Well-Being for All

Promote Regional Efforts

Input gathered during focus group discussions emphasized the range of barriers experienced by community members, such as: generational poverty; limited access to, affordability of, and availability of programs and services; stigma related to mental health issues and seeking treatment. At the same time, a sense of regional identity and shared experience were apparent. Survey respondents shared a strong desire for more community events where they can get more information about healthy eating, healthy behaviors, and mental health.

As such, collaborative partners and stakeholders may consider planning and implementing **community-wide campaigns** that address stigma and other attitudes or beliefs in the region related to behavior change efforts. For example, national organizations such as **National Alliance on Mental Illness** have online campaigns to increase awareness of and reduce mental health stigma. Local campaigns could be developed in partnership with well-known individuals (from and/or living in the region) who are interested in and willing to lend their support to Behavioral Health, Children's Health and/or Chronic Disease efforts.

Farmer's Markets have shown an increase in fruit and vegetable consumption in rural communities[1]. Markets across a region can also serve as a platform to disseminate information about healthy eating, education about the Supplemental Nutrition Assistance Program (SNAP), and support efforts to educate the public about health overall in partnership with other organizations working towards similar goals. The **Farmer's Market Impact Toolkit** provides a step-by-step guide to plan activities and also track the results of those activities towards improving health.

[1] Farmers' market use is associated with fruit and vegetable consumption in diverse southern rural communities. Jilcott Pitts SB, Gustafson A, Wu Q, Leah Mayo M, Ward RK, McGuirt JT, Rafferty AP, Lancaster MF, Evenson KR, Keyserling TC, Ammerman AS. Nutr J. 2014 Jan 9;13:1. doi: 10.1186/1475-2891-13-1.

Establish an Evaluation Framework

Although evaluation is often thought of as being a grant or other regulatory requirement, its purpose extends beyond reporting. Having an evaluation framework enables staff to: monitor progress towards program goals and objectives; identify opportunities for mid-course adjustments and improvements; demonstrate progress to partners and stakeholders; as well as justify the need for additional funding.

CDC's Framework for Program Evaluation is comprised of six steps:

- Step 1: Engage Stakeholders
- Step 2: Describe the Program
- Step 3: Focus the Evaluation Design
- Step 4: Gather Credible Evidence
- Step 5: Justify Conclusions
- Step 6: Ensure Use and Share Lessons Learned

CDC's evaluation resources, including the **WISEWOMAN Evaluation Toolkit**, provide guidance on each step and describe how to develop an evaluation framework in order to monitor progress, measure outcomes, and document lessons learned. In addition, templates are available to design plans for engaging evaluation stakeholders and collecting and analyzing data.

As noted earlier, in order to achieve collective impact, a group of partners must have a shared measurement system (in addition to other criteria). To effectively coordinate mutually reinforcing activities that make up a coalition's common agenda, an evaluation framework is essential for tracking and measuring efforts. Without an evaluation plan in place, partners and stakeholders collaborating on activities will not know whether their efforts are aligned nor if (and how) each organization's activities are contributing to shared goals and objectives in the region.

Implement Policy, Systems and Environmental Change

Policy, Systems and Environmental (PSE) change refers to changing policy (e.g., laws, rules, regulations), systems (e.g., organizational processes or rules), and the environment (e.g., physical changes) to support the health and well-being of communities.

Action 4 PSE Change describes the power of implementing PSE to support long-term, sustainable behavior change at the population level – compared to "traditional" public health programs focused on individual behavior change through education or other short-term touch points. Simply put, PSE change makes 'the healthy choice, the easy choice'. As such, it is essential to identify opportunities to implement PSE in diverse settings, including worksites, schools, faith institutions, community centers, etc.

Community input revealed that there are limited opportunities for physical activity and exercise. It was noted that the game: Pokémon Go created a widespread sense of excitement in the community. Community members of all ages were outside, physically active and engaged. This observation appears in the literature, which has documented how "**exergames**" can increase physical activity and result in physical, social and cognitive benefits. For example, schools throughout West Virginia integrated exergames into the physical education curriculum.

The **National Conference of State Legislatures (NCSL)** outlines steps for increasing access to farmer's markers, building associated nutrition programs, and expanding local food systems. In 2007, Tennessee implemented SB 131, which exempts farm products that are marketed and sold directly by farmers to consumers via a nonprofit online farmer's market from sales taxes. Additional policy expansion related to SNAP and farmer's markets would support collaborative programs and activities related to healthy eating, chronic disease prevention, and health education.

The **Prevention Institute** states: "Healthy people require healthy environments, neighborhoods, schools, childcare centers, and workplaces. People need their environments to be structured in ways that help them access healthy foods and easily incorporate physical activity into their daily routines." The Prevention Institute, along with other national agencies, have suggested policies, strategies and opportunities for implementing PSE broadly, including the **Health in all Policies** collaborative, multi-sectoral approach. (See *Tools & Resources* for more information.)

Conclusion

Based on the findings from all data sources, some high-level recommended strategies for addressing the core health issues in the region include:

1. Establish a strong regional collaborative or network to increase the coordination, sustainability, and impact of efforts.
2. Build the professional capacity of stakeholders to address mental health in the community.
3. Develop a mental health campaign to address stigma for targeted audiences (e.g., children, parents, men, older adults).
4. Partner with health providers in the region to ensure the Chronic Care Model (CCM) is implemented consistently across primary care practices.
5. Leverage and expand farmer's markets to increase the availability and accessibility of healthy foods in the community.
6. Promote physical activity for children and families in partnership with school-based stakeholders.
7. Consider opportunities to implement Health in All policies that cut across sectors to support sustained, community-level change.

The implementation of these strategies may be broken down into a phased approach with activities being rolled out over time. Laying the groundwork for collaboration will be critical for implementing activities with key stakeholders and improving outcomes related to behavioral health, children's health, and chronic diseases.

Tools and Resources

The following online resources (listed in alphabetical order) offer a range of tools and more detailed information that may support the above summary of recommendations.

- **Action 4 PSE Change**: http://action4psechange.org/
- **CDC**
  - **Community Health Improvement Navigator:** https://www.cdc.gov/chinav/resources/index.html
  - **Framework for Program Evaluation:** https://www.cdc.gov/eval/framework/index.htm
  - **Health in All Policies:** https://www.cdc.gov/policy/hiap/index.html
  - **Principles of Community Engagement**: https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf
  - **WISEWOMAN Evaluation Toolkit**: https://www.cdc.gov/wisewoman/evaluation_toolkit.htm
- **Chronic Disease – Improving Care Management**
  - Chronic Care Model**:** http://www.improvingchroniccare.org/
  - Primary Care Team Guide: http://www.improvingprimarycare.org/
- **Collective Impact Forum** – Getting Started (including *Launching Collective Impact Toolkits and Guides*): https://www.collectiveimpactforum.org/getting-started
- **Community Toolbox**
  - Creating and Maintaining Partnerships: https://ctb.ku.edu/en/creating-and-maintaining-partnerships
  - Leadership Development: https://ctb.ku.edu/en/building-leadership
- **County Health Rankings** – Getting Started with Policy Change: https://www.countyhealthrankings.org/take-action-to-improve-health/learning-guides/getting-started-with-policy-change
- **Exergames**
  - Influence of Pokémon Go on Physical Activity: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5174727/ (J Med Internet Res. 2016 Dec; 18(12): e315)
  - Exergames for Physical Education Courses: Physical, Social, and Cognitive Benefits: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3339488/ (Child Dev Perspect. 2011 Jun; 5(2): 93–98)
- **Farmer's Markets**
  - Farmer's Market Expansion – National Conference of State Legislatures (NCSL): http://www.ncsl.org/research/agriculture-and-rural-development/farmers-market.aspx#tn2
  - Farmers Market Impact Toolkit: https://www.demonstratingvalue.org/resources/farmers-market-toolkit
- **Mental Health First Aid**
  - https://www.mentalhealthfirstaid.org/

    - Rural Mental Health First Aid: https://www.mentalhealthfirstaid.org/external/2018/01/rural-mental-health-lacking-mental-health-first-aid-can-help/
- **National Alliance on Mental Illness**
    - https://www.nami.org/
    - https://www.curestigma.org/
- **Plan 4 Health** – PSE Changes in Rural Communities: http://plan4health.us/pse-changes-in-rural-communities/
- **Prevention Institute –** Strategies for Enhancing the Built Environment to Support Healthy Eating and Active Living: https://www.preventioninstitute.org/publications/strategies-for-enhancing-the-built-environment-to-support-healthy-eating-and-active-living
- **Promising Practices** database on HCMC's CHNA platform: https://www.hcmc-tn.org/about-hcmc/our-community/community-health-information
- **Rural Health Information Hub**: https://www.ruralhealthinfo.org/
- **Robert Wood Johnson Foundation** – Building a Culture of Health: https://www.rwjf.org/en/cultureofhealth/taking-action/fostering-cross-sector-collaboration.html

Appendix

The following files have been uploaded in a shared folder, for convenient access and downloading: https://drive.google.com/drive/folders/1i1aDX1Tt0Eo3vvJ33lEOjfEWaw2l4iPL?usp=sharing:

- Community Resources:
  - Results from Aunt Bertha search
- Primary Data:
  - Focus Group Interview Guide
  - Grow Well Community Survey Built Environment by County – 10-22-2019
  - Grow Well Community Survey – CD and BH by Age – Oct 2019
  - Grow Well Community Survey Analysis
  - Grow Well Community Survey – Oct 2019
  - Grow Well Community Survey Open Ended Question Responses – 10-22-2019
  - Grow Well Resource Inventory
- Secondary Data:
  - Secondary Data Workbook
  - Demographics Data Workbook